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ARTICLES

'MSM' as a 'doing thing'

An ethnographic genealogy of sexual alterity and the emergence of global health in Postcolonial Namibia

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Abstract

Drawing upon long-term ethnographic research in Namibia, I examine the label 'MSM' through a materialist interpretation of affect, viewing 'MSM' as a 'doing thing' that unsettles the boundaries between subjects and objects. From this analytic perspective, I reconsider the 'MSM' label as an inadequate signifier that overlooks, conceals, or erases social complexity. Instead, this perspective reveals what happens when the MSM label travels, thereby better accounting for the socialities it is instrumental in making up. Its very design and appearance – which portray bodies and behaviours in universalistic ways – allow this 'doing thing' to gain entry to diverse spaces where it comes to exist alongside some contentious postcolonial political formations, such as those surrounding LGBT rights. I argue that although the label is designed to be insulated from politics, as a 'neutral' behavioural category, when 'MSM' travels it is still highly relational, continually entangling itself in contexts, stirring up postcolonial anxieties, and reinforcing global inequalities, while also setting the stage for global health worlds coming into being.

Keywords

MSM, global health, HIV, ethnography, assemblage, Namibia

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Introduction

In this essay, I analyze a noticeable shift I observed, between 2001 and 2012, in the research practices of the University of Namibia (UNAM) Department of Health Sciences based in Windhoek, Namibia, a shift that related to the possibility of doing HIV research with sexual-nonconforming Africans.

As a Canadian doctoral student in 2001, I began working with the UNAM health sciences faculty, comprised mostly of nursing professors, on a Fogarty-funded social science and qualitative research capacity-building project. The Canadian and US anthropologists leading the project requested that I present an account of how eastern Canadian LGBT lesbian and gay activists in my hometown had mobilized a grassroots response to the HIV epidemic.[1] They had hoped that my presentation would begin a conversation in our group on the issue of same-sex HIV transmission, as it pertained to Namibia. However, the UNAM faculty members strenuously objected to the idea of including sexual nonconformity in their research focus. One of the UNAM professors commented during a workshop, rather assuredly, 'It is very interesting to hear about what has been happening in Canada, but homosexuality does not exist in Namibia the way it does in Canada and the US'. This refusal aligned with global epidemiological declarations at the time that framed Africa as having a 'heterosexual epidemic' while largely denying the possibility of same-sex HIV transmission on the continent (Lorway 2006).

Namibian students I came to know, through their daily attendance of the capacity-building workshops, claimed that the faculty's reticence to include sexual nonconformity among their approved research topics was a product of their allegiance to the ruling party, the South West African People's Organization (SWAPO), which publicly and vehemently disavowed the legitimacy of 'LGBT Africans' by casting their sexualities as forms of colonial residue (Lorway 2014). I soon learned that the health sciences faculty of UNAM, a government-subsidized institution, were unwilling to oppose this political rhetoric within the context of our Namibia-North American research training partnership.

The refusal of the UNAM faculty to consider the health needs of sexual-nonconforming Africans, at the time, appeared alongside the undeniable visibility of LGBT rights-based social movements that had gathered momentum in the southern African region since 1995 (Currier 2012; Epprecht 2013). In Windhoek, vibrant antihomophobia protests, staged by the LGBT rights organizers of The Rainbow Project (TRP), filled the streets of

1 For further details of this ethnographic work see Lorway (2017).

Independence Avenue and captured front-page headlines when I began my ethnographic field research, especially following then President Nujoma's infamous call to arrest, imprison, and deport LGBTs people in Namibia in 2001. UNAM faculty referred neither to the existence of these social movements nor to the organizers who led these protests during our early discussions of HIV risk and vulnerability.

Cut to 2005. The UNAM health sciences unit becomes a key country partner on a Johns Hopkins-led public health research team seeking to uncover HIV prevalence and risk behaviours of 'men who have sex with men' (MSM) across Southern Africa, placing the health sciences unit at the centre of what came to be regarded as a groundbreaking study that unveiled extremely high prevalence among African MSM (Baral et al. 2009). In the years that followed the renowned 'prevalence probe', the UNAM health sciences faculty became a vital producer of epidemiological knowledge on MSM in Namibia in collaboration with the Ministry of Health and Social Services and CDC-Namibia,[2] the implementing partner for the US President's Plan for Emergency Relief (PEPFAR). More intriguingly, the UNAM health science researchers throughout this period worked in close collaboration with TRP, the only national NGO focused on LGBT rights, whose presence they had denied when my research began.

How do we understand this dramatic shift – from a reticence to pursue research on 'LGBT Namibians' to becoming the main producer of epidemiological knowledge on 'MSM'? Certainly, the end of Nujoma's term as president, with the election of Hifikepune Pohamba in 2004, signaled new possibilities for those of us working in the area of health with sexual-nonconforming Africans in Namibia.[3] And accepting funds from an internationally recognized academic institution like Johns Hopkins aligned with and fed into UNAM's ambitions to grow their department beyond a small nursing unit. The postcolonial emergence of a vibrant transnational research program on MSM in Namibia in many ways exemplifies how global health science has come to thrive in African contexts, namely, by extracting value from the very inequalities it aims to illuminate and ameliorate (Crane 2013, 7). Cultivating an HIV research program related to MSM in close partnership with TRP, the UNAM faculty capitalized on pre-existing, transnational development efforts to advance LGBT rights that already flourished around the multitude of atrocities committed against

2 Tied to the Centers for Disease Control and Prevention (CDC) in Atlanta, CDC-Namibia was established in 2003.

3 Under President Pohama, anti-LGBT utterances were markedly reduced, although in September 2005, Deputy Minister of Home Affairs and Immigration Theopolina Mushelenga, addressing the village of Omaalala in Ongwediva, said that gays and lesbians were responsible for the HIV epidemic in Namibia.

LGBT Africans. Collaborations with TRP indeed proved vital for recruiting and making up MSM as a 'standardized population' (Nguyen 2009, 2013) that could then be intervened upon by a global health apparatus that co-emerged with global funding and administrative directives supplied by PEPFAR.

There is, however, another important element in this story of transformation that relates to the role of the protagonist – the MSM category itself – and the function of its design as a 'decontextualized' term. The transformative potential of the category MSM, as a vital thing rather than a passive object (Ingold 2010), lies in what many health scientists, health professionals, and activists encounter as its especially compelling character, that is, its seemingly culturally neutral appearance. Emphasizing behaviour, as though it could be separated from sociality or politics, opens up imaginations to the idea of an 'apolitical space' where researchers, policy makers, and activists alike can intervene in sexual alterity without rousing postcolonial anxieties or entering the inflamed political arenas where LGBT rights are contested. Therefore, rather than insisting on how global health deployments of the MSM category obfuscate a fuller view of gender and sexual diversity in all its complexity, as many critical scholars do, I instead present an ethnographically based genealogy of the term 'MSM' to illuminate the work that this category does in opening up a field of possibilities for a diversity of social actors pursuing global health knowledge production enterprises, thus helping to account for what anthropologist Tom Boellstorff (2011, 287) refers to as the accelerated or 'untimely' presence of the MSM category.[4]

Troubling the critique

Many critical scholars have interrogated what they consider to be the unproblematized use of the term 'MSM', as it recurs in health programs and scientific writing, doing so on the grounds that this label presents a decontextualized and universalistic articulation of human existence that elides social complexity and daily lived realities. In sum, these theorists consider the term as an inadequate and somewhat crude and simplistic signifier of sexual alterity, as the following excerpts make plain:

4 Boellstorff (2011, 287) wrestles with the question of how MSM, as an emergent form of selfhood, has been taken up globally so swiftly 'without the social and political organizing associated with so many claims to identity'. My analysis here takes much inspiration from his genealogical approach, which tracks how the category 'MSM' transforms from 'a category primarily excluding other notions of sexuality and gender to a category primarily including them' (2011, 288), although I offer a more materialist rendition of its makings in global health.

> In the 1990s, epidemiologists appropriated the category 'MSM'. Although the category was originally created to refer to non-gay identified men, its public health appropriation transformed MSM into a catch-all category, lumping together all MSM, independent of social identities or sociocultural and community ties. ... The remaking of this category into *'MSM' erased the initial concern with social identities and obscured the social organisation of sexuality*. (Garcia et al. 2016, 1027; emphasis added)

> Given this failure of the MSM category to incorporate non-exclusively straight men, in this article we explore an alternative. In place of a sole focus on sexual behaviour, we propose that *public health efforts must acknowledge and seek to understand the sexual desires and identities of those men*, avoiding in the process the tendency to simply see them as anomalous because of their lack of concordance with strict definitions of heterosexuality, bisexuality, and homosexuality'. (Carrillo and Hoffman 2016, 924; emphasis added)

> Thus, the term MSM risks *oversimplifying the diversity of relationships, identities and behaviours in which men participate,* in addition to the range of mental, emotional and physical health risks that arise from this participation. It is not enough to simply identify MSM in Eastern Europe. Once identified, it is crucial to explore the diversity of Eastern European MSM's identities, sexual practices and risks. (Meyer et al. 2010, 956; emphasis added)

> The problem with the MSM category is that *many men do not identify with this label, which leads to their increased alienation from HIV prevention strategies*. … Moreover, by imposing this category or developing programs under this framework, the *behavioral dominance may exclude key elements of the erotic-sexual interaction*, such as sex with women, which are critical to the main aim of the MSM approach – HIV/STI (sexually transmitted infections) prevention for bisexually-active Latino men and their partners. Thus, we need to move beyond MSM if we want to have a better understanding of Latino male bisexuality. (Muñoz-Laboy 2004, 58–59; emphasis added)

Calling for greater nuance, as Rebecca Young and Ilan Meyer do in *The Trouble with MSM* (2005), these critiques portray the failure of the MSM category to capture social complexity: it overlooks forms of pleasure, eroticism, and intimacies between people and the wider spectrum of their diverse desires. Furthermore, because the MSM category obscures or effectively erases important social identities and contextual realities, its iteration in global health programs runs the risk of overshadowing the specific health needs of groups who may not readily fit under the heading of 'MSM'. The concern here is often driven by the idea of failure to 'reach' or meet the health needs of particular people. Ethnographic attention to

sociopolitical complexity enters here as the methodological saviour, holding up the promise of illuminating these overlooked realities.

A second line of criticism cultivated by anthropological analysis surrounds the conflation of MSM with what Kaplan and colleagues (2016, 826) aptly refer to as 'trans feminine people', a critique that hinges on the potential miscasting of individuals as 'men' or 'male':

> To include trans feminine individuals in the MSM category, one does not simply have to adopt a 'biologized understanding of maleness', as Boellstorff puts it. Whether we adopt a hormonal, genetic, or gonadic definition of sex – or a combination of these three criteria as it is often the case when it comes to assigning a sex to individuals who do not fit clearly in the sex binary – trans feminine people may, or may not, be considered male.

As Matthew Thomann (2016, 994) notes, there are important public health implications that arise from this conflation with the MSM category, including the unintended exclusion of transfeminine people from vital health services:

> Constructions of gender and sexuality within HIV/AIDS programming obscure the complex social realities of sexual and gender minorities in Abidjan, Côte d'Ivoire. Drawing on research conducted in Abidjan among les branchés – a local term encompassing several categories of same-sex desire and practice including travestis and transgenres, woubis, yossis, and increasingly 'MSM' – I explore the erasure of difference and the creation of new boundaries of belonging and exclusion in the context of increased HIV prevention programming targeting Ivoirian sexual and gender minorities.

Running across these critiques are questions and concerns that pertain to self, identity, personhood, subjectivity, and subject position, which, as Adam Green (2010, 317) reminds us, are not only 'a feature of late modernity' but 'also a feature of contemporary critical social theory'. In sum, these critiques assert that the MSM category offers a poor and unequal stand-in for subjects who have long occupied the focus of anthropology and social philosophy. In this sense, MSM can be viewed as especially troubling to more enduring critical scholarly dispositions.

Cultural studies scholar Andil Gosine (2009, 29–30) exposes what he considers to be the implicit racializing and neocolonial overtones in health and development discourses of MSM, which depicts men of colour as not (yet) fully 'modern':

> The articulation of men engaged in homosexual sexual practices in the global South as MSM reassures a characterization of them as sexual deviants requiring the regulatory interventions of the state, both for their own survival as well as the state's. Identification of the MSM as a 'high risk' entity in development serves several purposes. The naming of men engaged in homosexual sexual acts in the global South (as well as non-white men in the global North) works to inferiorize both the acts and the men participating in them. MSM is to 'gay' what barbarian is to citizen: a figure with unbridled sexuality, lacking both self-control and responsibility, and dangerous.

According to Gosine (2009, 31), deployments of the MSM category in development serve as an instrument of racialized governmentality that conceptually and effectively divides the West from 'the rest' in the name of health security:

> Interestingly, most statistics about MSM come with a caveat about their volatility and unpredictability because of issues of secrecy and the men's failure to connect with fixed modes of sexual identification. Such an analysis of MSM provides a predictable response: that the only way forward is adherence to Euro-American models of sexual regulation practice. Men are encouraged to join groups and perform sexual identities, making it easier for their sexual behaviours to be known, assessed and managed.

In this article, I depart from these critical lines of scholarship in order to examine the emergent socialities and terrains of politics that redeployments of the MSM category give birth to in global health. My involvement in empirical studies and applied public health projects over the past two decades has led me to consider how it might be analytically fruitful for global health scholars to treat the label 'MSM' as a kind of vital thing in and of itself. I approach 'MSM' as a kind of nonhuman actor that exerts agency (without assigning it intentionality) so as to better understand how a diverse set of projects, political commitments, and notions of being attach to it. This analytic approach, I argue, helps us to avoid moralistic pitfalls that blunt the significance of what actually happens when this category travels and, instead, better account for the forms of sociality it is instrumental in making up. Drawing upon cultural studies theorist Jo Labanyi's (2010) materialist interpretation of affect, which attempts to unsettle the boundaries assumed to exist between subjects and objects, I illustrate how particular characteristics of the category 'MSM' gives it a presence in the world as a 'doing thing'. First, its very appearance – which reflects the universalistic notions of bodies and behaviours, free from cultural signification – allows this 'doing thing' to gain special entry into diverse geographies and domains of practice and implant itself in some rather thorny political terrain, sometimes inserting itself into projects without disturbing the more volatile arenas of LGBT rights. Second, as an identification, when recorded in research protocols, program attendance registries, clinician intake sheets, and outreach contact forms, its appearance animates systems of access to social and health

services, social networks, financial opportunities, and other resources. Third, 'MSM' plays a powerful mediating role in holding together diverse groupings of people (scientists, policy makers, community activists, and outreach workers), despite their many competing interests, social class disparities, and unequal shares in the dividends of the global health industry.

Many aspects of the mobility and utility of 'MSM' as a doing thing are rather unremarkable, because it was in the first place designed to do this kind of work. From this perspective, 'MSM' can be viewed less as an inherently dehumanizing category and more as a vital element in the workings of a heterogeneous assemblage that enacts a form of what I call 'strategic reductionism'. We must also attend to the moments when and places where the effectiveness of 'MSM' breaks down. Although designed to be insulated from politics, when 'MSM' travels it is still highly relational, continually entangling itself in contexts, stirring up postcolonial anxieties, and reinforcing and confirming global inequalities, while also transforming the ground of sexual politics itself.

Fertile silences

The UNAM Health Sciences department currently boasts an accredited medical school with health professional programs (in medicine, pharmacy, nursing, and public health), state-of-the-art resources for the modern anatomical sciences, and high student enrolment (Wessels et al. 2012), owing to the university administration's commitment to developing degree programs with the establishment of the institution in 1992, following Namibia's independence. Inspiring these developments, the SWAPO antiapartheid leader and first president of the Republic of Namibia, Sam Nujoma, made several postcolonial declarations in 1992 that tied the enhancement of postsecondary education to social improvement and nation-building political agendas (Fumanti 2006).

In 2001, when I began my ethnographic research, the UNAM Health Sciences department only offered diplomas and certificates in nursing, which attracted a small number of students, many of whom attended the early HIV capacity-building workshops led by the team of Canadian and US researchers I was invited to join. Given the high prevalence of HIV among adults, more than 20 percent at the time, the lack of universal access to effective antiretroviral medications (until 2003), and the fact that AIDS was the leading cause of death among adult Namibians, our capacity-building workshops took on a tone of urgency. In the years that followed the trainings, student enrolment in the health sciences at the university exponentially increased, a growth that the dean of the Health Sciences faculty, Dr. Lischen Hoases-Gorases, attributed to 'the demand for health professionals' to respond to HIV/AIDS and tuberculosis (New Era Reporter 2007). Major flows of foreign development

aid from PEPFAR, via CDC Namibia, furnished this tremendous growth in the intellectual economy surrounding HIV.

Although my early attempt to open a discussion of sexual nonconformity and HIV transmission was met with silence on the part of the UNAM health sciences faculty, during coffee breaks, two faculty approached me and, to my surprise, said 'It *is* a big issue in Namibia'. They both suggested that my doctoral research could explore the rapidly rising HIV prevalence among men within the context of Windhoek's notoriously overpopulated prison population. The faculty reasoned that I would be able to explore HIV transmission between men without having to tread on the inflamed territory of 'gay rights'. 'Sex between inmates', by contrast, they reasoned, was based on the circumstance of being in prison rather than contingent on any kind of sexual identity.[5]

My initial attempts to explore the subject of HIV transmission in prisons soon raised some troubling concerns around the epidemic facing incarcerated people. Meetings held with officials from the Ministry of Prisons and Correctional Services in Windhoek revealed an unsettling contradiction: they clearly recognized the severity of the HIV epidemic in Namibian prisons, which was reflected in their annual reports, yet they were entirely opposed to distributing condoms to inmates. Justifying this position, one of the head corrections officials stated, 'Sodomy is illegal in Namibia and, anyway, they [inmates] are here to be punished – not for pleasure. Otherwise we may as well just give them blow-up dolls!' My concern grew as two corrections officials suggested that the potential participation of inmates in my research could be tied to their 'good behaviour' and, to my alarm, even considered in their parole applications.

After the Ministry of Prisons and Correctional Services gave me a letter that declared I had permission to conduct research, I travelled to the Windhoek Central Prison Visitors Centre to meet with two HIV-prevention counsellors who were, I was to discover, discreetly providing condoms to prisoners unbeknownst to corrections officials.[6] Their HIV-prevention work was also discouraged by other prison staff, and they complained that they had paltry resources for carrying out their day-to-day prevention work. During our discussion, one of the counselors expressed her dismay with the ministry's policy of

5 This logic, of course, fits with problematic notions of 'situated' or 'pseudo-homosexuality', which I interrogate elsewhere (Lorway 2010).

6 I can now mention this practice without risking exposing the identities of the prevention workers because they are no longer working there and also the prison has changed its policies and provides condoms to inmates through the nursing stations.

prohibiting condom distribution to inmates: 'It is just so hard to get condoms into the hands of the inmates. There is no support, you see, for the work we are doing. How can we prevent HIV like this? And it is getting worse, worse, worse in here!' I soon realized that my proposed project on HIV vulnerability in prisons, although important, was not feasible for my PhD and would likely only serve to disrupt the counselors' sensitive and unlicensed HIV-prevention activities, carried out under the radar of the corrections ministry.

Given the myriad ethical flags raised during these exploratory visits, I shifted my research topic, particularly after I learned of the antihomophobia protests led by the national LGBT rights organization, TRP. My early meetings with TRP organizers soon revealed the negative consequences of the silences surrounding the HIV epidemic confronting this community. With the recent deaths of TRP members from AIDS-related illness, the organizers welcomed any research that could help shed light on the community's struggle with the epidemic. To acquire my research visa, however, I needed to return to UNAM to gain institutional support for my application. One of the health sciences professors, who knew me from the capacity-building meetings, looked at my proposed research statement, which included the intent to collaborate with TRP, and, with a crinkled brow, said, 'You know there are people in Ovamboland in the North, where I am from, and there are people there – you know, two women or even two men – they are living together; but people don't call it anything. People "know" but they don't say anything about it. They don't name it!' After a pause to reflect, she signed the form with an ambivalent expression on her face, while almost muttering to herself, 'Ok. But yes, it does exist'.

Her initial hesitation to sign my form – which would connect her approval to TRP, an organization explicitly deploying LGBT identifications at the time – did not stem from an unwillingness to acknowledge sexual alterity among African Namibians. Rather, her discomfort was with having it named using categories explicitly tied to Euro-American identity politics. She was not lacking in empathy for the health struggles of sexual nonconforming individuals: in subsequent discussions with her, she expressed considerable concern over their health and well-being. Nor was she unaware of the fuller social complexities that surrounded same-sex intimacies. Instead, her hesitancy spoke more to an effort to think through the consequences of authorizing research involving sexual nonconformity under the stifling conditions created by the antigay utterances of ruling politicians. Indeed, this period, between 2001 and 2002, allowed very little creative space within which government-subsidized institutions, like UNAM, could pursue interventions that promoted the health of sexual nonconforming people. At the same time, within this terrain of silences, the conditions of possibility and appeal of working with sexually nonconforming people under the category of MSM, without reference to social identity,

were sown. For this reason, 'MSM' soon gained traction in the health and development sector throughout southern Africa.

Encountering MSM

After conducting extensive ethnographic field research between 2002 and 2003, I re-encountered the issue of HIV transmission in Namibia's prisons, this time at the International Conference on Men, HIV & AIDS, sponsored by the Regional AIDS Initiative of Southern Africa (RAISA). Held in Pretoria, South Africa, in 2003, this well-attended conference engaged a broad array of activists, policy makers, researchers, and practitioners involved in service delivery and advocacy, working in sub-Saharan Africa: Namibia, South Africa, Lesotho, Zimbabwe, Zambia, Malawi, Mozambique, and Kenya. RAISA organizers invited TRP and Namibia's Ministry of Prisons and Corrections Services to present research findings in one of ten concurrent presentation streams, under the title 'Man-to-Man Transmission'.

The director of TRP, Ian Swartz, began the session with a presentation on the 'challenges that gay men face in African society', offering a cross-country account of rights violations. This talk stimulated heated discussion and debate around notions of traditional African sexuality. He did briefly employ the full phrase 'men who have sex with men', referencing those who do not identify as gay and who were 'missed' by LGBT rights organizations and public health with respect to HIV prevention:

> Many men who have sex with other men do not identify as gay. We must also not forget that in settings such as prisons and mining camps, many heterosexual men engage in homosexual acts. The perceived distinctions between homosexual and heterosexual people are not as clear as most people believe. (VSO-RAISA 2003, 20–21)

My presentation followed that of the director; I spoke about the 'same-sex sexual risk practices' of township youth who identified as gay, bisexual, and transgender, some of whom were living with HIV. I also articulated how discriminatory social conditions shaped their vulnerability to HIV.

Both our talks, which employed LGBT identifications, sparked negative reactions from some of the African attendees during the group feedback sessions, especially among the Malawian contingent, who were proudly displaying a rather colourful (and female objectifying) 'fat thigh' social marketing campaign for condoms. One of the Malawians warned the conference attendees, 'We need to be careful that gay issues don't hijack the main issues'.

Next to speak in the 'Man-to-Man Transmission' presentation stream was a white South African professor of sociology who provided a lengthy laundry list of sexual practices engaged in by his research participants, who were predominantly white male sex workers. This talk further stirred the discomfort of many attendees. The murmur of complaints grew around the voyeuristic nature of the presentation that seemed to exotify male sex work, presenting what some attendees, especially expats, saw as excessive details of behaviours that seemed unrelated to HIV transmission.

Then, a young Namibian researcher and health sciences student at UNAM, speaking on behalf of the Ministry of Prisons and Corrections Services, gave a talk entitled 'Men-to-Men Transmission', in which he stated that it was not uncommon for inmates to have sex with each other. However, he also maintained: 'Homosexuality is regarded as a criminal offence in Namibia and therefore condoms are not provided to inmates. It is believed that should condoms be provided it might promote sodomy'. He told the audience that his prevention group, as part of their health promotional work, 'demonstrate the proper use of condoms to men in prison and supply each one of them with a condom on completion of sentence' (VSO-RAISA 2003, 22). This presentation ignited further disagreement among the audience members, who saw this as an egregious lack of regard for the sexual health of prisoners.

The dissonance between the messaging of TRP and correction services representatives made for a rather uncomfortable dinner conversation later in the evening. The corrections staff were displeased with the subject matter of the talks delivered by the TRP representative and me. One of them asked me, pointedly, 'How could you put Africans in such a bad light!' One of the TRP members retorted, asking why they only gave condoms after prisoners were released, if they knew they were having sex with each other. The corrections representative responded, 'Of course we give condoms to the men, but we can't *say* that, you know, publicly'.

As the tension began to subside, I inquired about intimate partnerships forming between the inmates. The corrections representative explained, 'You know, we do have men who are in long-term relationships, like husband and wife almost. But we can't say publicly that they are in a gay relationship'. As the corrections researcher continued, it became clear that the use of the term 'men-to-men', which deliberately avoided reference to sexual identity, served as a highly pragmatic tool for doing HIV prevention in institutional spaces with inmates as it allowed them to navigate a postcolonial minefield of prohibitions that delegitimated African sexual alterity. Interestingly, that evening TRP and Corrections Services researchers did find some common ground on the use of the term 'MSM', which was mentioned in a number of presentations.

Spurring far less debate, a representative from the Population Council of Kenya delivered a presentation entitled 'Understanding the Sexual and Reproductive Health Needs of Men Who Have Sex with Men'. The presenter referred to the two community-based organizations that they partnered with on the study, Galebitra and Ishtar, as 'MSM associations'. Although she briefly acknowledged that they both held LGBT rights mandates, she consistently referred to the survey participants from these two organizations as 'MSM respondents'. Unlike Ian Swartz's use, which referred *only* to individuals *not* taking up a gay identity, the Population Council representative employed 'MSM' as a less intimidating stand-in for participants who claimed gay, bisexual, and transgender identities.

The term 'MSM' quickly gained popularity among the conference attendees and was eventually included in the 'rapporteur' feedback sessions during the conference and in the list of acronyms in the final conference summary document. During the conference, 'MSM' soon came to function as an umbrella term that referred to a highly diverse ensemble of identities, behaviours, and social contexts, from gay, bisexual, and transgender-identifying Africans to non-identifying Africans, and from white South African male sex workers to Namibian prisoners. However, rather than seeing the term 'MSM' as masking, erasing, or eliding these registers of sexual difference, it is also worthwhile to note the tremendous work the term accomplished in assembling heterogeneous networks of unruly contestations, identity politics, and diverse actors and domains of health practice.

The category 'MSM', although providing some immediate relief to the tensions at the RAISA conference, certainly did not do away with the existing stirrings, debates, and controversies over Africa sexuality. By adopting the term 'MSM', those working in these different domains of practice (human rights advocacy, corrections, public health, academia, and so on) did not suddenly lose touch with or disavow the complexity and perspectives of the groups of people they regularly worked with (white male sex workers, LGBT youth, incarcerated men, and so on). Instead, the plasticity of 'MSM' as a 'boundary object' (Star and Griesemer 1989, 393) – crossing several domains of practice, terrains of politics, and registers of analysis – effectively gathered together the contesting voices of the RAISA participants into a dissonant concert, thereby making the possibility of a single population of MSM imaginable to a broad range of health and development actors.

The makings of a unified sample

Findings from the groundbreaking study of HIV prevalence among MSM in Southern Africa, led by Johns Hopkins-based health scientist Stefan Baral and colleagues (2009), profoundly disrupted conceptual distinctions upheld by epidemiologists between the 'gay epidemic' in the West and Africa's 'heterosexual epidemic', thereby opening up a space to

initiate health interventions in a group previously excluded from HIV surveillance. The category of 'MSM', employed in the multicountry study that included Namibia, Botswana, and Malawi, furnished Baral's study team with the ability to 'construct uniformities' (Timmermans and Epstein 2010, 71) out of vastly different subjectivities, identity politics, forms of intimacy, cultural milieus, and political arrangements. This maneuver was made possible by virtue of the features of the category itself, which presented a simplified way of sorting diverse groups of people together, that is, through a mechanical and socially reductive portrayal of behaviour. In other words, the MSM category enabled Baral's team to imagine and create a unified 'sample size' and, in so doing, construct an interpretive backdrop that lent itself to epidemiological calculations of HIV risk, to ensure that the knowledge they produced about human vulnerability could be legible to the statistical sciences. Thus, the category of MSM played a pivotal role in a process I call 'strategic reductionism', which allowed the category to work through Baral and his team in building a scientific narrative of human vulnerability that appears to avoid entanglement in the messier postcolonial realities in which African sexualities are embedded.[7]

This 'purification' process (Latour 1993, 10–11) – in this case, the attempt to separate sexual acts from their cultural moorings – mobilizes universalistic ideas of bodies and behaviours. The effects of this reductionism appeal to health scientists precisely for this reason, for a hollowed-out view of sexuality permits the establishment of a standardized global system of ranking regions according to country risk profiles (such as those that UNAIDS annually publishes), thus rendering 'progress' in tracking responses to HIV epidemics a globally comparable reality.

The MSM category, as deployed by Baral and his team, also facilitated the assembly of new local partnerships, in each of the country sites, between African health scientists and community activist groups publicly working for the advancement of LGBT human rights.[8] In fact, the success of the 'prevalence probe' hinged on the engagement of community-based organizations, whose participation was prized by health scientists for the network ties they

7 I am grateful to the anonymous reviewer who offered insight into how I might refine my thinking on strategic reductionism in relation to how MSM might 'work through' these scientists.

8 In Malawi and Namibia scientists collaborated with the staff of community-based organizations. However, in Botswana this did not happen, which is why, perhaps, there is a much lower sample size.

held to 'hidden' people and their 'insider knowledge' of how to reach them, undisturbed, without risking disclosures (Baral et al. 2009, 2).[9]

Further assuring that 'hidden' MSM were reached, all country sites employed respondent-driven sampling, a type of snowball sampling technique that selects community members as 'seeds', who are expected to select and recruit others from their networks into the study (Heckathorn 1997). Although, as a purposive technique, this sampling method poses challenges for statistical approaches compared to conventional randomized sampling procedures, the study team employed it at all the country sites following the logic that respondent-driven sampling permits the sampling of 'hidden' people for whom a sampling frame is unknown (Salganik 2006).

The Johns Hopkins team identified and hired as their study coordinator TPR's health officer, Danoab,[10] a young, publicly open HIV-positive, gay African activist, with many years of experience working in sexual health. His role in Namibia involved working in close collaboration with faculty from UNAM's newly established HIV/AIDS unit, in the Faculty of Health Sciences. During my discussion with Danoab in 2006, he spoke with tremendous pride of his role on the project and expressed considerable optimism, anticipating that the government's obvious omission of gay and bisexual men in the Namibian National HIV/AIDS strategy would be overturned by the eventual study results. Danoab also saw his position as an opportunity to reconnect with his educational aspirations and further his pursuit of postsecondary education. He was quite pleased to establish a working relationship with the UNAM HIV unit, which he regarded as a major achievement: 'Previously it has been very difficult to work with them [UNAM Health Sciences faculty] on anything to do with LGBT people, because they see us [TRP organizers] as violating the government, because we talk about LGBT rights, you know. But now it is, you know, it is about MSM and public health; so it's not as political, you know, and it is easier for them to justify working with us'.

After his first attempt at recruiting participants through respondent-driven sampling, I met up with Danoab in his home in Katutura township. He seemed to be in an especially good mood. Describing the sampling process with a gleam of excitement in his eyes, he said, 'You wouldn't believe what it was like. We started with the "seeds" from TRP and then they

9 'Given the hidden nature of MSM in these communities, participants were recruited by in-country [community-based organizations] with experience working with gay, bisexual, and other MSM' (Baral et al. 2009, 2).

10 This is a pseudonym.

brought us their sexual partners. Oh my god! I mean these guys, their boyfriends, were *so* masculine. They are a totally different group from TRP members. You would not believe how they looked!'

Other TRP members who had been part of the recruitment process made similar comments, reiterating terms like 'homothugs' and 'gangsters' in their descriptions of a group of young men they had 'never seen before'. Thus, an almost fetishistic atmosphere pervaded the respondent-driven sampling process at TRP around the unveiling of their members' sexual network and connections to ordinary working-class men who appeared 'untouched' by the cosmopolitanism of TRP's transnational queer milieu. The TRP participants I spoke to about the sampling process characterized this group of men as completely ignorant of same-sex HIV transmission and therefore somehow dangerous, which also fed into their eroticizing depictions of them. The excitement around these men, as objects of scientific 'discovery' and erotic desire, and as threatening from an HIV transmission perspective, cast them as a group that had 'yet' to feel the embrace of LGBT and public health modernities.

On the one hand, this fetishization of working-class masculinities speaks to Gosine's (2009, 29–30) concern over how the use of the term 'MSM' in development programs tends to cast, in particular, men of colour and those in the global South as the 'figure of unbridled sexuality' in their 'failure to connect with fixed modes of sexual identification'. On the other hand, under the heading of MSM, 1) a new demographic of people became linked to the project of intervening in sexual difference in Namibia, 2) TRP expanded its developmental influence into the lives of ordinary people, and 3) the logics and procedures of global health science extended more deeply into Namibian society, compelling people to produce the hidden 'truth' of African homosexualities. Attending to how the MSM category here compelled local people to reflect and comment on their sexual networks, while also stirring their excitement, especially helps us to understand the affective undercurrents that animated the horizontal makings of a standardized MSM population 'urgently' requiring intervention, a population that came into being as the boundaries of 'the community' swelled to engulf new groups of people, including those who refused sexual identifications.

Data tampering?

Toward the end of his involvement on the epidemiological study, Danoab looked noticeably upset, telling me: 'Robert, you wouldn't believe it – so many of the [HIV testing] kits are spoiled!' I responded, 'What do you mean, "spoiled"?' He explained: 'You see, the nurse from UNAM, she was doing the [HIV saliva detection] tests; she was in the other room and she started freaking out, you know, because so many of the men were testing positive. I think she was taking them [the swabs] out of the [reactive] solution before they were ready.

The [second confirmatory] line is – you can see, it was just starting to form, but it's faint, like it had not been allowed to completely form!' I suggested that he immediately inform the principal investigator, who, along with Danoab, inspected the spoiled testing kits. Later, Danoab told me, that the principal investigator had decided the results from those kits couldn't be included in the findings.

Given that there were just over two hundred participants, the results from the more than twenty spoiled kits (assuming that they would have yielded HIV results if left in the reactive solution longer) could have considerably increased the HIV prevalence among MSM for the Namibia country site. I asked Danoab why he thought the nursing researcher had done such a thing and he said, 'I guess she thought it looks bad to the world with so many MSM testing HIV positive in Namibia. Cause we are already known for our homophobia!'

As Danoab's statement suggests, the MSM category had reached a limit in what it could achieve in averting political entanglements. Whether deliberately tampered with or not, what is clear from the emotions expressed around the spoiled kits is how the apolitical promise of the category could not entirely shield MSM and the scientific project attached to it from postcolonial identity politics in Namibia. Indeed, the case of the spoiled kits offers more to the story than the question of data tampering and fabrication; it also foreshadows the growing permeability of the MSM category to politics as it began to travel outside the protective and pristine boundaries of scientific research protocols and into the messier arenas of global health development and population governance.

Purity lost

With the growing recognition of the HIV vulnerability of MSM in southern Africa, following the 'prevalence probe' led by Johns Hopkins, international development funders and policy makers began to increasingly focus on health and sexual alterity in southern Africa in ways that drew together epidemiological and LGBT rights rationalities. As the MSM category circulated among distinctive domains of practice (academic health science, civil society and development, and governmental policy making), further entangling them, the purification process facilitated by the MSM category, which moved to keep sexual acts insulated from postcolonial politics, began to break down. The growing permeability of 'MSM' as it migrated across various boundaries of practice translated into the rise of hybrid development projects that merged techniques from the health sciences with approaches that advanced notions of human rights. For instance, in 2007 the Dutch-based LGBT humanitarian foundation Schorer launched its development program known as the Prevention Initiative

for Sexual Minorities (PRISM) in Botswana, Zimbabwe, Namibia, and South Africa.[11] This development program – drawing heavily upon epidemiological notions while also decrying the discrimination perpetuated by the Namibian state – thereby advanced forms of 'impure science', to borrow words from science and technology studies scholar Steven Epstein (1996). The following excerpt from the project's final assessment report helps to illustrate how MSM categories, development targets, and LGBT identifications appear together in hybrid form, that is, as a melange of epidemiological and rights-based rationalities that announce evidentiary concerns as forcefully as concerns for the exceptional suffering of LGBT Africans:

> Namibian leaders, as in many African countries, have used official and party platforms to deny the existence of lesbian, gay, bisexual, transgender and intersex (LGBTI) people by accusing Western countries of importing 'a homosexual culture' into Namibia. This silence makes LGBTI Namibians particularly vulnerable to HIV infection given the lack of attention paid to their health care needs in relation to prevention, care and support services. This matches with statements made by the United Nations General Assembly's Special Session on HIV … [that] indicators pertaining to MSM have not been met. For example, indicator 19 ('percentage of men reporting the use of a condom the last time they had anal sex with a male partner') has not been collected by the Namibian government. The report further states that there is limited data on the sexual practices and the socio-sexual network size of MSM. (The Rainbow Project 2008, 3)

The growing intimacies between developmental logics and epidemiology that encircled sexual alterity in southern Africa, facilitated by the MSM category, soon created the conditions of emergence for a global health apparatus to crystalize under the advance of PEPFAR-CDC programs. When PEPFAR began in 2004, very little information on the HIV vulnerability of MSM existed. However, as the high prevalence of HIV among MSM came to light between 2006 and 2008, PEPFAR began to fund and push for increased surveillance of 'MSM populations' in sub-Saharan Africa (Needle et al. 2012).

A variety of evidentiary techniques travelled with PEPFAR-CDC's goal of managing the sexual risk of MSM and other 'most at-risk populations' (which included female sex workers) in Namibia. These techniques include the geographic mapping and enumeration of 'key populations', biological-behavioural surveillance, and biometrics to track new service delivery

11 As a volunteer research consultant, I led the qualitative research methods training for the local data collection team working on the needs assessment.

and utilization systems (cf. Lorway 2017). This emergent global health apparatus, therefore, can be best described as 'precision oriented' in its approach to measuring and governing the enrolment of people in prevention, treatment, and care programs. And the MSM category – now a broad standardized umbrella term for various behaviour, identities, and genders, while still maintaining its aesthetic of political neutrality – abetted movements to solidify the definition of a 'target group' for health development in Namibia. The MSM category ushered in the creation of a new subpopulation (a 'key population') that could be treated as distinguishable from an imagined 'general population'. This imaginary, which was precipitated by the MSM category, reinvents Namibia's heteronormative society, in decontextualized and non-postcolonial terms, as a population in need of continual defense from sexual alterity. The technocratic order that materialized under the emergent global health apparatus proceeded to discipline and mobilize the fragmented, contested terrain wrought by the increasingly blurred boundaries of science, development, and governance, an unruliness fostered by the plasticity of MSM as a doing thing. And through a performative process, the new evidentiary procedures designed to track MSM altered and produced socialities to conform to its logics (Callon 2009).

In one sense, this technocratic regime can be viewed as rerouting the momentum of LGBT rights organizing efforts toward the production of standardized global health knowledge. In another sense, the global health apparatus, orchestrated by PEPFAR-CDC, can be understood as imposing uneven collaborations and reluctant partnerships among local LGBT organizers, government health officials, and local and foreign health scientists. This became clear to me in 2012 during a visit to the office of Outright Namibia,[12] a new national LGBTI rights NGO that replaced TRP. I spoke with Danoab who was now responsible for working with a multinational consortium of partners affiliated with PEPFAR-CDC. He expressed frustration and concern over recent negotiations at a partnership meeting that included a PEPFAR representative, a US-based health scientist, a national health official, and two UNAM health scientists, whom he described as 'blatantly anti-gay'. Danoab said, with exasperation, 'I can't believe we are forced to work with those [UNAM] researchers! [They] are so homophobic and I don't really trust them'. In particular, he was concerned about the consortium's intent to introduce electronic fingerprinting as a biometric for tracking the utilization of health services by 'MSM and sex workers' to see if there were patterns.

To shed light on how these kinds of inflamed partnerships emerged, I return to the period of 2007–2008, when the global health apparatus was just beginning to take hold and become intertwined with organizing to ensure sexual minority rights. Although the category of MSM

12 TRP shut down in 2009 amid allegations that donor funding was being misappropriated.

presented itself in epidemiological exercises as a neutral, universalistic behavioral category, free from the cultural entanglements of local identity politics, when it entered the fray of global health development in Namibia, it drew together a diverse consortium of global health actors, binding them in a relation of continual friction.

Indecent proposals

In January 2008, a relatively small but diverse group of decision makers gathered in a meeting hall in a modestly priced hotel, located just off Sam Nujoma Avenue, the main street running through the coastal city of Walvis Bay. The group included two LGBT rights organizers, five national officials from the Ministry of Health and Social Services, and four European public health consultants, affiliated with a Dutch university. Under the guidance of a Ugandan-born, UK-educated consultant, who was highly experienced in writing PEPFAR proposals, the group spent three weeks developing HIV funding proposals to submit to PEPFAR.

The TRP director invited me to attend the writing workshop as a long-time allied researcher, and he asked me to support them in their efforts to ensure that the Ministry of Health did not 'drop' any references to MSM during the proposal process. Although MSM was explicitly mentioned in the PEPFAR call for proposals, the TRP organizers were fearful that health officials would refuse to recognize the vulnerability of this group. And indeed, their fears were soon realized. Despite the visibility of TRP members, who, in fact, were invited to the meeting at the request of PEPFAR and CDC-Namibia, two of the government health officials tried to dismiss the importance of the susceptibility of MSM to HIV infection on the very first day.

One official stated, 'The prevalence is only 12 percent among MSM, so it is still much lower than our adult population. You see, you can't really call them a high-risk population'. Heated dispute broke out over just how high the HIV-risk level was for MSM in Namibia, and the debate continued for some time until the facilitator suggested we break into smaller groups.

During the small-group discussions, two TRP activists and I approached the Dutch public health consultants and presented them with a folder of studies and grey literature we had accumulated on HIV and MSM in different African nations. We urged them to support us in the goal of having MSM included in the proposals. However, the consultants maintained that they could not 'force the issue of MSM' with the government health officials because, as they put it, 'We cannot meddle in these kinds of local cultural matters'.

Another vigorous debate broke out around the category WSW (women who have sex with women). In the PEPFAR call for proposals, 'WSW' were grouped together with other 'high risk' women such as sex workers and women involved in transactional sex. The government health officials, who claimed to be unfamiliar with the term, promptly raised objections upon hearing the meaning of the term. One exclaimed, 'How can *they* be at risk for HIV infection!?' The TRP representative responded, 'We know a lot of our members who are lesbians and they are living with HIV'. 'But the risk of transmission between ladies is very low risk', another health official chimed in. The TRP representative maintained, 'Many of these women will have sex with men, in exchange for money, just like many women do in our country'. The first health official retorted: 'But that has nothing to do with them being a lesbian. It is because they are having sex with men. *That is heterosexual behavior* that is giving them HIV!' 'But you see', the TRP director continued, patiently, 'Lesbian women or closeted WSW become infected in their own unique way, because they get pressure from their family to have sex with men, sometimes for money for the family, or sometimes to have children. It is happening to them. Sometimes there are lesbians who are sexually assaulted by men who think they can make them straight'.

This issue continued to flare up over the coming weeks, and the category of WSW quickly came to take on political inflections that engaged both sides of the debate. Consensus was never fully reached with respect to the meaning of WSW as a 'high risk group' in the proposal, yet the group seemed to agree that these women suffered unique forms of discrimination that made them particularly vulnerable to HIV infection and therefore worthy of inclusion. Although carrying with it the conflicted political views of both government officials and LGBT rights crusaders, the term 'WSW', like the MSM category, continued to be used in Namibian global health development arenas in the years that followed.

Overwriting culture

In 2012, Danoab shared with me a draft protocol for a surveillance study known as the Integrated Biological Behavioural Surveillance Survey (IBBSS), the gold standard of monitoring and evaluation procedures for HIV programs targeting 'key populations' globally. The technical leadership for the IBBS study, he explained, was provided by CDC-Namibia, which had been designated as a 'PEPFAR implementing agency'. In close collaboration with the UNAM Faculty of Health Sciences, CDC-Namibia had begun funding two training programs: 'frontline health care worker disease detection, investigation, and response' and 'field epidemiology and laboratory' techniques (PAMWE 2014, 22). They also trained an array of health professionals (medical officers, nurses, pharmacists, and public health specialists). In January 2014, UNAM and CDC-Namibia jointly launched the first ever master's of science program in applied epidemiology. Thus, PEPFAR HIV funding flowing

to UNAM's health science and health care educational programs, via CDC-Namibia, was instrumental in growing the UNAM Faculty of Health Sciences.

As I examined the draft IBBSS protocol Danoab gave to me, I noticed how MSM and female sex workers (abbreviated as 'FSW' in the document) were grouped together under the term 'MARPS' (most at-risk populations) as a subpopulation considered to bear the burden of the HIV epidemic. The study also coupled the surveillance survey with a geographic mapping and size estimation procedure with the aim of enumerating 1) the specific locations where these populations congregate to find sexual partners/clients and 2) the distribution of these groups across these 'hotspots'. Although MSM appeared in the protocol in its epidemiological form (in other words, with reference to risk behaviours without identities), there were, nevertheless, numerous slippages toward sociocultural thinking that appeared. Take for example the following phrases scattered throughout the protocol: 'MSM field teams', 'MSM volunteers', 'MSM counselling issues', 'MSM services', 'MSM organizations and websites', 'MSM communities', and 'MSM-friendly institutions'. The multiple deployments of the category, I argue, worked to overwrite 'LGBT' identities, as familiar texts and phrases in LGBT health and development were altered to fit the aesthetic of scientific neutrality. Yet, despite this attempted purification within global health, MSM as a mechanical and hollowed-out behavioural category failed to remain fully separated from its sociopolitical moorings; instead, it became increasingly entangled in cultural signification, edging ever closer toward individual and collective social identities.

Conclusion

Having empirically studied, over the past decade, the complex sociopolitical workings of community-based organizations that are led by sexual and gender nonconforming people throughout Asia (particularly in India and China) and Africa (in Namibia and Kenya) – at the intersection of social movements and public health – I have noticed striking uniformities in the intervention discourses that pervade global health programs aimed to mitigate the HIV pandemic. This appearance of uniformity within activist organizations, at first glance, implies the depoliticization of LGBT rights, the domestication of sexual dissidence under the standardizing rule of a global health sovereign that seems to be remaking the world in its own scientific image. The aesthetic of this ordering system in many ways can be tied to various global health imperatives (for example, in standard guidelines and operating procedures, best practices, precise reporting requirements, and so on) that increasingly insist that community-based organizations implement precision-oriented, evidentiary regimes to govern people's access to vital health care resources.

However, reconstructing an ethnographic genealogy of MSM as a 'doing thing' disrupts this linear narrative of social transformation, of global imposition, succession, power and subjugation. Affording a grounded, horizontal view of the various social makings of MSM, my approach reveals how a standardized population comes into being through a situated, irregular, and unpredictable process of entanglement. Sociality and politics do not vanish beneath the gaze of a global health (and primarily North American) sovereign; rather, 'MSM', as a vital thing, stimulates and births lively new forms of sociality as it fosters the creation of heterogeneous assemblages that span distinct domains of practice, notions of being, and historical registers of postcolonial politics. This story of entanglement, which departs from scholarly narratives depicting the erasure of sexual alterity, is important for understanding how science diffuses in postcolonial African contexts (Rottenburg 2009). It does so as much through the critical engagements of those fighting for LGBT rights in global health enterprises as through the purifying practices of scientists and governmental policy makers who attempt to implement standardized protocols that measure and monitor MSM's access to health services. At the same time, political movements around sexual alterity are less 'depoliticized' by redeployments of MSM than reconfigured in such a way that transforms the very ground of sexual politics, as new political alliances, fractures, and perspectives get rediscovered within technical frames of reference (Lorway et al. 2018). Anthropologists Ashley Currier and Tara McKay (2017, 75) aptly note that many rights-based collectives in southern Africa today have coalesced into 'hybrid organizations, addressing a combination of public-health and social-justice issues raised by their diverse constituents'. From the perspective of entanglement, in the senses that both Achilles Mbembe (2001) and Ian Hodder (2012) have articulated,[13] medical anthropologists working in the interstices of LGBT organizing and global health are well positioned to ethnographically analyze the threads of subtext that are intertwined with various over-writings performed by the MSM category, and to chronicle the doings of 'MSM' – which make up as much as *reflect* the heterogeneity of global health worlds coming into being.

13 My thinking in this article owes much to Achille Mbembe's (2001, 14–16) notion of entanglements in relation to postcoloniality. Mbembe theorizes the postcolony, in important ways, as a temporal formation, 'as an era of dispersed entanglements, the unity of which is produced out of differences. From a spatial point of view, it is an overlapping of different, intersected and entwined threads in tension with one another. Here, the task of the analyst is to tease out those threads, to locate those intersections and entwinements', an aim I have attempted with respect to the MSM category as a 'doing thing'. I also take seriously the ideas of archeologist Ian Hodder (2012), whose analysis illuminates how humans and things co-constitute each other, although he calls for greater attention to things in and of themselves, and how they grow, transform, and fall apart.

About the author

Robert Lorway is Associate Professor of Community Health Sciences in the Centre for Global Public Health, University of Manitoba, where he holds the Canada Research Chair in Global Intervention Politics and Social Transformation. As a medical anthropologist, his research explores how contemporary global health interventions shape new forms of subjectivity and collective existence. He has written two books on the subject, *Namibia's Rainbow Project: Gay Rights in an African Nation* (Indiana University Press, 2014), and *AIDS Activism, Science and Community across Three Continents* (Springer International Press, 2017). Robert's conceptual engagements are firmly rooted in public health projects conducted in close collaboration with health and social justice activists.

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